Guidance on the Role of Hospice Services in LTC Facilities During COVID-19 Pandemic

Long-term care facility residents and staff are experiencing a number of stressors and losses. LTC facility staff are experiencing challenges both personally and professionally. This has increased the need for hospice's holistic, end-of-life care for patients and families as well as grief and bereavement support for residents, families and staff. It is critical that LTC and hospice staff partner together to ensure simple, clear and supportive communication, minimizing mixed messages.

To prevent the spread, facilities and health care workers need to significantly reduce the number of people entering and interacting with residents and staff. This needs to be balanced with providing the most benefit to the resident and family, especially at the end-of-life. The risk-benefit must be made on a case-by-case basis, incorporating the best interest of the resident, against the risk of introducing the virus to other residents, a cohort that has a very high morbidity and mortality rate. According to the CDC Morbidity and Mortality Weekly Report, the current mortality rate ranges from 10-27% for elderly over the age of 85. This decision process will need to be adjusted as the COVID-19 situation evolves in each local community and building.

Some Broad Principles to Consider

1. Use alternate methods to conduct the visit (phone call, phone with video, or other device with audio and video capability), particularly for routine visits.
2. Minimize the number of different hospice staff dedicated to a SNF.
    a. Consider assigning staff to facilities and minimizing entry into multiple buildings as movement of staff between buildings is suspected to be one mechanism of COVID-19 spread.
    b. If COVID-19 is discovered in a building, hospice staff should strongly consider limiting their movement to other buildings and self-monitor for fever or respiratory symptoms.
3. Bundle visits to minimize the number of different days hospice needs to be in the building.
4. Maximize the number and types of care and services provided by a single staff member (hospice or LTC) to minimize different people needing to enter a room, particularly at COVID spreads.

Assessing Resident Status

Assess current status to determine stability of patients.

1. Is pain/symptom management under control?
2. Are there active signs and symptoms of approaching death?
3. Are there complex family dynamics or psychosocial issues?

Questions to ask prior to arranging a visit:

a. Who needs to provide this service (hospice or facility staff)?

b. Can it be accomplished by phone call, phone with video, or other device with audio and video capability? Can the facility staff help the patient connect?

Caring for Stable Patients

1. Use alternative methods of completing routine updates, assessments, interventions such as telehealth technology. Reserve in-person visits for patients whose condition warrants and can't be accomplished by other mechanisms.
2. Review the care plan with patient as appropriate, family and staff and consider modifying the current plan to minimize number of in-person contacts and include phone or telehealth visits in the care plan.
3. Bundle visits on different days to a single day.
4. Ensure frequent and consistent communication with family to provide updates and answer any questions.

Questions to ask prior to arranging a visit:

a. Who needs to provide this service (hospice or facility staff)?

b. Can it be accomplished by phone call, phone with video, or other device with audio and video capability?

c. Are there other hospice staff already conducting a visit?

Patients Approaching Death[1]

1. In these situations, implement CMS guidance for hospice providers and work to allow visitation by family, again trying to minimize entry.
2. Consider adjusting the care plan to minimize number of different staff entering building.
3. Hospice nurse could consider providing both hospice support and care but also ADLs or other nursing care during a visit to help minimize interactions with staff.
4. Consider engaging hospice for added psychosocial and spiritual support, expertise and resources for residents not enrolled in hospice but who are approaching end-of-life. There may also be an opportunity for hospice admission for those who are actively dying of COVID. This may free up staff to provide care to other residents in the facility.
5. Most people are afraid of dying alone and hospice staff can help.

[1] Assess for signs of approaching death and determine whether "pre-active phase of dying" or "active phase of dying". The pre-active phase of dying could last a couple of weeks versus the active phase of dying could last about 3 days.

Questions to ask prior to arranging a visit:

a. Who needs to provide this service (hospice or facility staff) and how does it have to be done?

b. Are there other hospice staff already conducting a visit?

c. How can hospice staff help with family visits for dying residents?

Grief Support for Residents and Family

It is likely that this environment may result in tremendous amounts of complicated grief for many people. Interventions on the front end to support, guide, minimize anger and fear, can help mitigate some of the risk factors for complicated grief. Consider how hospice's expertise with grief and bereavement counseling, especially 13-month posthumous, can be beneficial to the residents and families. Given the restrictions on family member in-person interaction, hospice staff can be helpful in ensuring frequent and consistent communication with family.

1. Assess for appropriate hospice referrals.
2. Discuss with hospice partner options for grief support for residents and families, even for non-hospice patients.
3. Once interventions have been agreed upon, provide hospice with information on family members and friends as well as best approach in communicating with them.
4. It is critical that LTC and hospice staff partner together to ensure simple, clear and supportive communication, minimizing mixed messages.

Grief Support for Staff

Staff often form close relationships and strong connections with the residents in their facilities and as such, experience grief and loss upon a resident's death. Grief support for LTC staff is beneficial during ordinary times but gains even more significance during the current crisis, as the emotional toll of multiple losses of residents, compounded by concerns for colleagues and their own family members who are sick or at risk, cannot be underestimated. Hospice can be a beneficial resource in supporting staff.

1. It is important for facility staff to talk openly about their emotions to their colleagues or other support staff.
2. Discuss with the hospice partner how grief support may be offered to staff and potential strategies for support.
    - Hospice staff should note that facility staff are probably in the best position to offer feedback on which strategies may be most beneficial to the staff of their facility.
3. Ensure consideration of alternative methods for support versus in-person, assigning staff to facilities and minimizing entry into multiple buildings. If the movement is unavoidable, increased attention needs to be paid to infection control processes.

These are unprecedented times. We must work together in creative and supportive ways to maximize the benefits of the partnership. The threat of coronavirus to older adults and those with underlying health conditions has shown to have dire consequences, and we must do everything we can to prevent the further spread into LTC buildings.

CMS Guidance

QSO-20-16-Hospice: Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) by Hospice Agencies. (March 13, 2020)

QSO-20-14-NH: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED). (March 13, 2020)

COVID-19 Long-Term Care Facility Guidance (April 2, 2020)